# NEW PATIENT REGISTRATION

## WholeHealth, Inc
## 2522 N. Lincoln Ave.

**Chicago, IL 60614 773-296-6700**

**PATIENT INFORMATION** **Today's date:**

Last Name: ____________________ First Name: ____________________ Middle Name: ____________

Street Address: ______________________________ City: ____________ State: ________ Zip: ________

Home Telephone: (_______)_________-__________ E-Mail: ______________________ Fax #: (_______)________-__________

Birthdate: ______/_____/______ Age: ________ Social Security #: _______-________-_______ Gender: Male ____ Female ____

Occupation: ______________________ Student Status: Full Time: ________ Part Time: ________ Does Not Apply : ________

Employer: ______________________________ Work Telephone : (__________)__________- ______________

Employer Address: ______________________ City: ____________________ State: ____________ Zip: ______________

**RESPONSIBLE PARTY INFORMATION**

Last Name: ____________________First Name: ______________ Middle Name: ______Street Address: ______________________

City: __________________ State: ______ Zip: __________Home Telephone: (_____)_______- __________ E-Mail: __________________

Birthdate: _____ /_____/______ Age: _______ Social Security #: _______-_______-_______ Gender: Male _____ Female ____

Occupation: ______________________ Relationship to patient: Self _____ Spouse _____ Partner ______ Dependent ________

Employer: ____________________ Work Telephone: (____)_____- __________Employer Address: ______________________

City: __________________________ State: ________________ Zip:______________

**INSURANCE INFORMATION**

| Primary Insurance | Secondary Insurance |
|---|---|
| Address | Address |
| City / State / Zip | City / State / Zip |
| Insured Name / Date of Birth | Insured Name / Date of Birth |
| Policy I.D. # / Group #: | Policy I.D. #: / Group # |

**OTHER INFORMATION**

Illness/Injury is job related: ______ Yes ______ No

If yes, Date of Injury:______________________________

Employer: ______________________________

Employer Contact: ______________________________

Employer Phone #(_________)______________-______________

Illness/Injury related to an accident?: ________ Yes ________ No

If yes, Date of Accident: ______________________________

Do you have an attorney?: __________ Yes ________ No

Attorney Name: ______________________________

Attorney Phone #: (_________)______________-________________

How did you hear about our office: _____Yellow Pages __Personal Reference (Name):______________________Other:______________

**IN CASE OF EMERGENCY**

Name: ________________________Relationship: ______________ Address: ______________________________

City :_________________________ State:__________ Zip:____________Telephone #: (_______)__________-____________

PRIMARY HEALTH CONCERN:______________________________________________

**I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT.**
**I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE, I AM ULTIMATELY RESPONSIBLE FOR ALL SERVICES PERFORMED.**

______________________________ ______________
**PATIENT SIGNATURE** **DATE**

______________________________ ______________
**RESPONSIBLE PARTY SIGNATURE** **DATE**

# NEW PATIENT INTAKE FORM

**To our new patients:** Welcome to WholeHealth Chicago, Inc. To help us establish you with our practice, please complete the following form.
**This form has been designed to facilitate our patients' continuity of care at Whole Health Chicago, Inc. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.**

## Personal History Form

**Date**____________________________

Name: ____________________________________________ Date of Birth___/___/______ Age_____ M_______ F______
Address______________________________________________________ Phone Number__________________
Martial Status M S W D Number of Children__________ Ages of Children____________________________
Employer______________________________________________________ Occupation_____________________
Employer Address_______________________________________________ Work Number___________________
Date of Last Physical Exam__________ Your Doctor: ________________ Referred by: _______________________________

**ALLERGIES:**
_______________________________________________________________________________________
_______________________________________________________________________________

**MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT:** **(if possible, rank in terms of importance to you)**

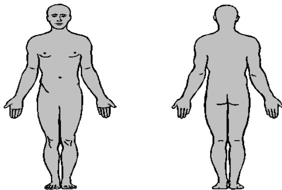
1. ______________________________________________________________________________
2. ______________________________________________________________________________
3. ______________________________________________________________________________
4. ______________________________________________________________________________
5. ______________________________________________________________________________

**Please list discomforts and date condition started:**

| Complaints (Location of pain, intensity, frequency, radiating symptoms and duration) | Date Started |
|---|---|
| 6. ____________________________________________ | ________________ |
| 7. ____________________________________________ | ________________ |
| 8. ____________________________________________ | ________________ |
| 9. ____________________________________________ | ________________ |

**Please describe aggravating / relieving factors**
_______________________________________________________________________________________
_______________________________________________________________________________________

**Please mark your areas of pain / discomfort on the figures**:



Is your condition getting worse? Yes No
Is your discomfort Constant or Off and on
**Have you seen other doctors for these conditions?** Yes No
(If yes, please list doctor, prior interventions, treatments medication and treatment dates.)
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________

**Have you experienced any accidents or falls within the:** Past Year Past 5 Years Never
(If you have experienced an accident, what type was it? Auto Work Home Sports Other)
Briefly explain:
_______________________________________________________________________________
_______________________________________________________________________________

| Current Medications | Dose | Times / Day |
|---|---|---|
| (Include Pain Killers, Muscle relaxers, Aspirin, Tranquilizers, Birth Control pills) | | |
| | | |
| | | |
| | | |
| | | |

| Current Herbs / Vitamins/ Supplements | Dose | Times / Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## PAST MEDICAL HISTORY

**(Prior illness, injury, hospitalization, surgery, trauma)**

| Reason: | Date: |
|---|---|
| | |
| | |
| | |
| | |
| | |

## PERSONAL AND FAMILY HISTORY: (check those that apply)

| | Yourself | Mother | Father | Grandparents | Sister/ Brother | Spouse | Children |
|---|---|---|---|---|---|---|---|
| AIDS | | | | | | | |
| Alcoholism | | | | | | | |
| Allergies | | | | | | | |
| Alzheimer's | | | | | | | |
| Anemia | | | | | | | |
| Arthritis | | | | | | | |
| Asthma | | | | | | | |
| Birth Defects | | | | | | | |
| Bleeding Disorder | | | | | | | |
| Breast Cancer | | | | | | | |
| Cancer | | | | | | | |
| Colon Cancer | | | | | | | |
| COPD | | | | | | | |
| Depression | | | | | | | |
| Drug Abuse | | | | | | | |
| Emphysema | | | | | | | |
| Epilepsy | | | | | | | |
| Glaucoma | | | | | | | |
| Heart Attack | | | | | | | |
| Heart Trouble | | | | | | | |
| High Blood Pressure | | | | | | | |
| IBS | | | | | | | |
| Kidney Disease | | | | | | | |
| Liver Disease | | | | | | | |
| Mental Illness | | | | | | | |
| Migraine Headaches | | | | | | | |
| Pneumonia | | | | | | | |
| Prostate Cancer | | | | | | | |

| Sickle Cell Anemia | | | | | | | |
|---|---|---|---|---|---|---|---|
| Stroke | | | | | | | |
| Suicide | | | | | | | |
| Tuberculosis | | | | | | | |
| Ulcers | | | | | | | |

**Patient Name:** ___________________________________



**SOCIAL HISTORY (check those that apply):**

| **Marital status:** | **Education level completed:** | **Memories of your childhood** | **Do You Find Your Life** |
|---|---|---|---|
| single | high school | Mostly happy | Generally Unsatisfactory |
| married | college | Mostly painful | Too Demanding |
| Divorced | professional school | Normal | Boring |
| other : | other: | don't recall | Satisfactory |

**Living arrangement:**
alone family roommate other
children (list ages):
Major stresses in last 6 months Money Job Marriage HomeLife Children
other:

**LIFESTYLE / SELF-CARE ISSUES**

| | | | | |
|---|---|---|---|---|
| Do you smoke cigarettes? | YES | NO | If yes, how many? | _______________ packs per day |
| Did you ever smoke? | YES | NO | If yes, when did you quit? | _______________ |
| Do you drink alcohol? | YES | NO | If yes, how much? | _______________ drinks per week |
| Do you drink caffeinated beverages? | YES | NO | If yes, which? | ___________________________________________ |
| Do you use recreational drugs? | YES | NO | If yes, which? | ___________________________________________ |
| Do you manage stress well? | YES | NO | NOT SURE | NEED HELP |
| Do you exercise regularly? | YES | NO | If no, why? | ___________________________________________ |
| Do you enjoy your job? | YES | NO | If no, why? | ___________________________________________ |
| Do you allow time to unwind and relax? | YES | NO | If no, why? | ___________________________________________ |
| Do you sleep soundly? | YES | NO | If no, why? | ___________________________________________ |
| Are you satisfied with your sex life? | YES | NO | If no, why? | ___________________________________________ |
| Are you satisfied with your social life? | YES | NO | If no, why? | ___________________________________________ |
| Are you satisfied with your spiritual life? | YES | NO | If no, why? | ___________________________________________ |
| Is your diet healthy enough? | YES | NO | NOT SURE | NEED HELP |

**Typical breakfast**_____________________________________________________________

**Typical lunch** _____________________________________________________________

**Typical dinner** _____________________________________________________________

**Typical snacks**_____________________________________________________________

**Devices**
**Do You Use:**

| | | | |
|---|---|---|---|
| **___Eyeglasses** | **______Contact Lens** | **______Hearing Aid** | **______Dentures** |
| **___Brace (Neck, Back)** | **______ Pacemaker** | **______ IUD, Diaphragm** | **______Artificial Limbs** |

Patient Name________________________________________



**Patient Reported Symptoms:** (Check any symptoms that currently apply to you)

| Constitutional | Ear, Nose, Mouth, & Throat | Muscles, Bones, & Joints | Digestion & Intestine | Eyes | Immune System | Blood System |
|---|---|---|---|---|---|---|
| __poor appetite | __headaches | __neck pain | __indigestion | __blurred vision | __too many infections | __anemia |
| __fevers | __jaw clicks | __back pain | __belching | __eye pain | __allergies to food | __easy bruising |
| __chills | __grinding teeth | __muscle pain | __heartburn | __poor vision day__ night__ | __allergies to environment | __chest pain |
| __food cravings | __trouble chewing | __painful joints: Right__ Left__ | __difficulty swallowing | __wear corrective lenses | __lymph gland swelling | __lightheaded |
| __weight loss | __facial pain | __shoulder | __nausea | __nearsighted | __other | __palpitations |
| __weight gain | __sore throat | __elbow | __liver trouble | __farsighted | | __cold hands or feet |
| __fatigue | __mouth sores | __hip<br>__knee | __vomiting | __other | | __fainting |
| | __bad breath | __ankle | __diarrhea | | | __swelling feet |
| | __ringing ears | __wrist<br>__finger | __cramping bowels | | | __blood clots |
| | __nosebleed | __joint swelling | __gassy gut | | | __varicose veins |
| | __postnasal drip | __muscle weakness | __constipation | | | |
| | __sinus problems | __muscle cramps | __abdominal pain | | | |
| | __trouble with taste/ smell | | __rectal pain/ itching | | | |
| | __poor hearing | | __hemorrhoids/ piles | | | |
| | __earaches | | __blood in stool | | | |

| Breathing & Lungs | Sexual Organs | Skin, Hair, Breast | Nerves, Brain, Movement | Women | Urine, Kidney, Bladder | Reproductive |
|---|---|---|---|---|---|---|
| __shortness of breath | __sores on genitals | __breast lumps or pain | __seizures | __pelvic pain | __painful urination | __age period started |
| __wheezing or asthma | __lumps or swelling | __breast leaks fluid | __nerve pain | __vaginal discharge | __wake up to urinate | __# of pregnancies |
| __repeated colds/ flu | __ erection problems | __rashes | __poor balance | __painful periods | __kidney stones | __pregnancies lost |
| __cough dry/ irritating | __poor sexual response | __itching, hives | __poor coordination | __premenstrual syndrome | __loss of bladder control | __past fertility problems |
| | __infertility | __hair loss | __tremors or shaking | __hot flashes | __frequent urination | __# of live births |
| | __repeated infections | __dry skin, eczema | | __itching or soreness | __sudden urge to urinate | __children currently living |
| | | | | | __blood /puss in urine | __age menopause |

Patient Name_____________________________________ 

**HEALTH SCREENING HISTORY** **List the date of your most recent test or exam**

Mammogram__________Pap Smear___________Self Breast Exam____________Breast Exam by Doctor_____________ Blood test for Anemia_________
Blood test for Cholesterol_____________Other Blood Tests______________________
Immunizations: Polio________Tetanus__________Hepatitis__________Pneumonia___________Flu Shot____________
Test for Blood in stool_______Rectal Exam ______________Feeling the Prostate_________Scope Lower Bowel________
Self Exam Testicle___________Testicle Exam by Professional_________ P___________G_____________

| | Xray | MRI | CT Scan | Ultrasound | Bone Scan | Pet Scan | EMG |
|---|---|---|---|---|---|---|---|
| Back | | | | | | | |
| Brain | | | | | | | |
| Chest | | | | | | | |
| Colon | | | | | | | |
| Extremities (Arm/ Leg) | | | | | | | |
| Gallbladder | | | | | | | |
| Kidney | | | | | | | |
| Neck | | | | | | | |
| Other | | | | | | | |
| Pelvis | | | | | | | |
| Stomach | | | | | | | |

**YOUR PRIMARY CARE DOCTOR'S NAME** ________________________________________**DR's PHONE #**_______________________________________

**YOUR PRIMARY CARE DOCTOR'S ADDRESS**________________________________________________________________________________

**MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR?** _________________________________________________________________

**I have reviewed and confirmed the information with the patient**

_________________________________________________________
**Date** **Physician Signature**

® WholeHealth Chicago, Inc. 5/8/00

**FINANCIAL POLICY**

Thank you for choosing WholeHealth Chicago as your health care center. We are committed to your successful treatment. Please understand that full payment of your bill is considered part of your treatment. The following is provided to avoid any misunderstandings concerning payment for professional services.

We accept cash, personal check, Visa, MasterCard, American Express, and Discover as forms of payment.

**Regarding Insurance.** We do not accept any HMO insurance policies, nor are we contracted with Medicaid. It is your responsibility to understand your benefits and the reimbursement policies of your insurance company. We do not verify insurance benefits. Please open your insurance company correspondence so that you are aware of their reimbursement decisions. It is vital that you provide us with correct and current insurance information so that your claims may be filed properly. A **rebilling fee of $10.00** will be charged if we must file a claim a second time due to inaccurate information that you provided. **All charges become your responsibility 60 days after insurance claims have been submitted.**

WholeHealth Chicago is "In-Network" with Blue Cross/Blue Shield PPO Plans only. All other insurance plans are considered "Out of Network".

**"In-Network" Insurance Plans.** All co-payments, co-insurance, deductibles, and non-covered services are due at the time of service. You are responsible for payment of all services your insurance company may deny.

**"Out-of-Network" Insurance Plans.** For your convenience, we will submit claims to most (not all) insurance companies. We require at least a 20% payment at the time of services and you are responsible for the payment of any balance that may remain after 60 days from insurance submission.

**Non-Covered Services.** Please be aware that some or all of the services provided may be non-covered services and not considered "reasonable and necessary" under the Medicare Program or other medical insurance. Therefore, it is our policy not to bill for certain services including acupuncture, massage, nutritional consultations, homeopathic consultations, vitamin therapy, intravenous therapy, or any other services considered ineligible by your insurance company.

**Missed Appointment – Our policy is to charge of missed appointments at the rate of a normal office visit unless cancelled at least 24 hours prior to the scheduled appointment.**

**Late Fees.** We depend on timely payment from our patients in order to keep our fees at their current level. To minimize the risk of a late fee, your credit card can be charged when a patient balance is due. Our Payment Agreement Form has an option to allow for a statement to be mailed to you so you may pay by check. If payment is not received within three (3) weeks of the statement date, the balance due plus a **$10.00 late fee** will be charged to your credit card.

If payment is not received within six (6) weeks of the first statement date, you will be referred to collections and will be charged a **$25.00 collection fee.** If you require payment arrangements, you must contact the office within three (3) weeks of the first statement date. Other financial charges include a **$25.00 returned check fee** and a **$10.00 rebilling fee.** Patients whose accounts are not in good standing will be asked to pay their balance prior to receiving additional services.

I have read, understand, and agree to this Financial Policy:

Signature ______________________________________________ Date ___________________

Relationship to patient (if minor)

_________________________________________________________________

## PRIVACY POLICY

With patient consent, Wholehealth Chicago may use and disclose protected health information to carry out treatment, payment, and healthcare operations only. Please refer to WholeHealth Chicago's Notice of Privacy Practices for a complete description of such uses and disclosures, available at the front desk.

WholeHealth Chicago will do its best to protect your private health information while allowing you access to your records.

- WholeHealth Chicago will not sell your information to any third parties for marketing purposes.
- WholeHealth Chicago will not release your information for any purposes without your signed consent.
- You have the right to review your medical records and make amendments to those records. Records may be obtained by submitting a written request to the office manager.
- You have the right to submit a written request that WholeHealth Chicago restrict how it uses or discloses your protected health information.
- You may revoke this consent in writing except to the extent that the practice has already made disclosures with this prior consent.

**Please initial where you consent to the following:**

_______ WholeHealth Chicago may call my home, or another designated number and leave a message, or with a person, regarding items that assist the practice in carrying out treatment, payment, and operations.

_______ WholeHealth Chicago may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

_______ WholeHealth Chicago may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

## CONSENT TO TREATMENT

The undersigned acknowledges that he/she has requested healthcare services. The doctors and practitioners of WholeHealth Chicago are authorized to perform any healthcare service deemed necessary. Many of the therapies offered at the center are considered unconventional and may be deemed "unproven" by the Food and Drug Administration. There is no obligation to accept or complete any therapeutic recommendations.

I hereby assign all benefit payments for services rendered under the terms of my insurance policy to be paid to WholeHealth Chicago.

**I have read the WholeHealth Chicago Privacy Policy and Consent to Treatment and thoroughly acknowledge, understand, and agree to all of the above information.**

Print name ______________________________________________________________

Signature ____________________________________________ Date ____________________

Relationship to patient (if minor) ________________________________________________

**E-mail Correspondence Policy**

Due to the ever-increasing number of e-mails received by Dr. Edelberg, WholeHealth Chicago will now be charging a nominal fee ($25.00) for **some** e-mail communications. Most insurance companies do not yet reimburse for e-mail correspondence, therefore, you will be responsible for this fee. A valid credit card must be on file with the office in order to utilize this service. Dr. Edelberg will determine those inquiries to be charged and, as a rule, will be limited to more complex issues. For example, "What time do I take my medicine?" or "Can you refer me to a dermatologist?" will not be charged. However, inquires describing symptoms, asking for treatment advice, and/or a prescription will be charged the $25.00 fee.

_________________________________ _________________

Signature Date

WholeHealth Chicago 3, SC
PATIENT CARE PAYMENT AGREEMENT

I agree to the following:
**For Charges billed to insurance**

1. WholeHealth Chicago will charge the credit card below for services not reimbursed by my insurance company after sixty (60) days.

2. WholeHealth Chicago will collect my outstanding balances including co-pays, co-insurance, deductibles, and non-covered services on the credit card below.

3. WholeHealth Chicago will refund any over-payment to the credit card below.

4. If I receive direct reimbursement from my insurance company for services not paid to WholeHealth Chicago, I will endorse that check and submit it to WholeHealth Chicago within five (5) business days. Otherwise, I authorize WholeHealth Chicago to collect the full amount of my account balance on the credit card below.

**For Charges not billed to insurance**

1. If I cancel an appointment with less than 24 hours notice, WholeHealth Chicago will collect the normal office visit fee on my credit card below.

2. If I make a payment by check that has insufficient funds, I authorize WholeHealth Chicago to collect the non-payment, plus $25.00 returned check fee on the credit card below.

3. If I require pre-authorization($25.00), letters ($25.00), insurance forms ($25.00), mailed prescriptions ($25), or e-mail medical assistance ($25.00), WholeHealth Chicago will automatically charge my credit card on file.

If the card number provided is invalid or does not accept charges, I understand that I may be subject to late fees and further collections.

NAME ______________________________________________________________________

☐ CREDIT CARD ACCOUNT ☐ DEBIT CARD ACCOUNT

☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMEX

CARD NUMBER _______________________________________________________________

EXPIRATION DATE ____________________________

SIGNATURE __________________________________ DATE ___________________

WITNESS ____________________________________ DATE ___________________

_______ I prefer to have statements mailed to me before charging my credit card so that I have the opportunity to pay by check. However, I understand that if payment is not received within three (3) weeks of the statement date, the balance will be charged to the credit card listed above, including a $10.00 late payment charge. *For balances less than $25.00, this is not an option.*